



Office of Radiation Safety

DOSIMETRY SERVICE - REQUEST FOR RADIATION BADGE (S)



Sign and mail or fax completed forms to:

Radiation Safety, MC3930 Fax: 3826

**FOR
OFFICE
USE
ONLY**

PARTICIPANT #:

P-1

MEDICAL

SERIES CODE:

P-13

RESEARCH

U-3

OTHER

Last Name

First Name

M/I

Gender

Maiden Name

Social Security #

OR

Date of Birth

Other I.D. (e.g.: Passport #, CT License #, Employee #)

Month Day Year

1. Department: _____ Room #: _____ MC: _____ EXT: _____

2. Authorized User: (Research Isotope Users Only) _____

3. Radiation sources you will be involved with: (please list all isotopes and/or all x-ray equipment, i.e., portable, fluoroscopy, dental, etc...)

Radionuclides: _____

X-ray equipment: _____
(list all radiation producing equipment you will be using)

4. Have you ever worked with radiation/radioactive materials and been issued dosimetry at the Health Center? Yes No

5. Did you work with radiation/radioactive materials and were issued dosimetry at another facility in the last 12 months? Yes No

NOTE: If you answered "Yes" to number 5, please provide the facility and address below.

FACILITY OF ISSUE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

Section 19-24-6 C of the State of Connecticut Administrative Code requires workers entering a high radiation area to wear a radiation dosimeter. You will be issued a dosimeter because we have determined that there will be a potential for exposures. You must wear dosimetry at all times while working with radiation and/or radiation producing devices. They **MUST** be returned to Radiation Safety by the end of the first week of every month after receiving your new one. Failure to comply with these requirements could result in suspension of privileges.

Signature

Date



University of Connecticut Health Center



Office of Radiation Safety MC-3930
Tel: (860) 679-2250 Fax: (860) 679-3826

Subject: Request for Radiation Exposure History

To Whom It May Concern:

The following individual was associated with your institution and has indicated he/she was occupationally exposed to radiation during that time. In order to comply with the provisions of 10CFR20, the University of Connecticut Health Center requests this individual's radiation exposure history while at your facility. Please include results of bioassays that contributed to the total effective dose equivalent he/she may have received.

Name	SSN	D.O.B.	From	To

Please forward exposure report to: **UNIVERSITY OF CONNECTICUT HEALTH CENTER
OFFICE OF RADIATION SAFETY MC-3930
263 FARMINGTON AVENUE
FARMINGTON CT 06030 - 3930**

Sincerely,

Kenneth W. Price, C.H.P., M.P.H., Director
Radiation Safety Officer

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL RADIATION EXPOSURE RECORDS

To whom it may concern:

I hereby authorize and request that all records of my radiation exposure history be released to the Radiation Safety Office, University of Connecticut Health Center.

Signature

Date